STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155756	A. BUILDING 00 B. WING	08/26/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENTRY MEADOWS	7843 W JEFFERSON BLVD FORT WAYNE, IN46804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	This visit was for Recertification and State Licensure Survey. Survey Dates: August 22, 23, 24, 25, 26, 2011 Facility Number: 004945 Provider Number: 155756 AIM Number: 200814400 Survey Team: Sheryl Roth RN TC Rick Blain RN Sue Brooker RD Diane Nilson RN Angie Strass RN Census Bed Type: SNF: 31 SNF/NF: 110 Total: 141 Census Payor Type: Medicare: 30 Medicaid: 75 Other: 36 Total: 141 Stage 2 Sample: 40 These deficiencies reflect state findings cited in accordance with 410	F0000	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation. Due to relative low scope and severity of this survey, this facility respectfully requests a desk review in lieu of a post-survey revisit on or after September 25, 2011.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F0223 SS=A	IAC 16.2. Quality review 9/02/11 by Suzanne Williams, RN The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on interview and record review, the facility failed to prevent verbal abuse of resident from staff. This affected 1 of 3 residents reviewed for abuse of 17 who met the criteria for abuse. (Resident #13) Findings include: Review of the clinical record for Resident #13 on 8/24/11 at 9:42 a.m., indicated the following: diagnoses included, but were not limited to, depression, senile dementia with depressive features, delusional features, and Alzheimer's disease. A family member of Resident #13 was interviewed on 8/23/11 at 2:51 p.m. During the interview she indicated staff were speaking loudly and yelling at Resident #13. She also indicated this was reported to the facility.	F0223	**F 223 Abuse** · It is the practice of this facility to protect all residents from verbal abuse of staff. However, based on the alleged deficient practice the following has been implemented: **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** · Resident #13 was evaluated by SSW for any signs/symptoms of psychosocial harm and none were noted. · CNA #7 was immediately suspended and terminated following investigation. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:**	09/24/2011

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	A Facility Incident Reporting Form, dated 4/27/11, indicated at approximately 6:30 p.m., the charge nurse was walking down the 400 hall and was passing the room of Resident #13. Resident #13 was heard to ask Certified Nursing Assistant (CNA) #7 a question to which CNA #7 responded she was busy helping the roommate. Resident #13 responded to CNA #7 she doesn't give a damn, to which CNA #7 responded in a loud rude tone of voice "I don't give a damn either." The incident was immediately reported and the CNA was suspended pending an investigation. Resident #13's family, physician and Director of Nursing were notified. Resident #13 and her roommate were evaluated and monitored for any signs of psychosocial harm. CNA #7 was terminated. A Social Service Progress Note for Resident #13, dated 4/28/11, indicated "...Res (resident) noted by ED (Executive Director) to have been an unusual event reported to state. Res has no negative psychosocial issues noted...." A Social Service Progress Note for Resident #13, dated 4/29/11, indicated "...Res talking w/ (with) her		· No other residents were found to have been affected by the alleged deficient practice. · All residents have potential to be affected by the deficient practice. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur:** · Staff Development Coordinator in-services all new employees on abuse; Annual Mandatory Training is done; and in-services after any alleged event. · All Managers are responsible to oversee compliance. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** · A CQI monitoring tool called Abuse Prohibition and Investigation will be utilized every week x 4, monthly x 3 and quarterly thereafter. · Data will be collected by	

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	aide and no apparent mood or psychosocial outcomes noted...." The facility Administrator was interviewed on 8/25/11 at 3:06 p.m. During the interview he indicated the facility had zero tolerance for abuse toward residents. A current facility policy "Abuse Prohibition, Reporting, and Investigation", dated February 2010, indicated "...It is the policy...to protect residents from abuse ...verbal abuse...defined as the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents...or within their hearing distance, regardless of their age, ability to comprehend, or disability...." 3.1-27(b)		Executive Director/Designee from 1 st , 2 nd , and 3 rd shifts and submitted to the CQI Committee. If threshold is not met, an action plan will be developed. · All staff was in-serviced on signs and symptoms of staff burn out that may result in verbal abuse by Staff Development Coordinator. · Staff Development Coordinator in-services all new employees on abuse; Annual Mandatory Training is done; and in-services after any alleged event. **Compliance date: 9/24/2011**	

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F0278 SS=D	The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement.			
	Based on observation, record review and interview, the facility failed to ensure the Minimum Data Set (MDS) Assessment was accurate for range of motion and life expectancy of less than six months for 1 of 40 residents reviewed for assessments in the stage 2 sample of 40. (Resident #53) Findings include: 1. On 8/24/11 at 9:45 a.m., Resident	F0278	**F 278 Assessment Accuracy/Coordination/Certified** It is the practice of this facility to ensure that the Minimum Data Set (MDS) Assessment is accurately completed for range of motion and life expectancy of less than 6 months for applicable residents. However, based on the alleged deficient practice the following has been implemented: **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient**	09/24/2011

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	#53 was observed sitting in the lounge with music playing, asleep. Bilateral hands of Resident #53 were closed into a fist. On 8/25/11 at 11:15 a.m., Resident #53 was observed sitting in a comfort chair in his room. LPN #10 attempted to open Resident #53's closed fisted hands. The resident grimaced and stiffened up and the nurse was barely able to open his hands enough to put one finger in the palm of his hands. The clinical record for Resident #53 was reviewed on 8/24/11 at 10:30 a.m. Diagnoses included, but were not limited to, left hip fracture, polio, and fractured left shoulder. The "Transdisciplinary Therapy Screening," dated 2/9/11, indicated Resident #53 had impaired range of motion. The MDS assessment dated 2/22/11, indicated Resident #53 had impairment in range of motion on both sides of his upper extremities and on one side of his lower extremities. The MDS dated 4/20/11, indicated Resident #53 had no impairment in range of motion of either upper or lower extremities.		**practice:** · Resident #53's MDS has been corrected to reflect the impairment of resident's Range of Motion. · Resident #53's initial diagnosis for requiring hospice services was brought forward reflecting diagnosis supporting terminal decline that was Advanced Dementia. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** · No other residents were found to have been affected by the alleged deficient practice. · Residents with chronic progressive disease with increased debilitation have the potential to be affected by the alleged deficient practice. · Therapy will evaluate residents on admission and on a quarterly basis. Findings will be relayed to MDS Coordinator · MDS will be updated by therapy via Therapy-to-MDS communication form to reflect resident's current Range Of Motion function. · Residents qualifying for hospice care will have qualifying diagnosis indicated on MDS. · In-servicing was done September 9, 2011 by MDS Coordinator. · MDS Coordinator/Designee and Nurse Management are responsible for overseeing compliance. · Resident #53 has a clarification order stating diagnosis of end stage dementia and MDS will be updated at next quarterly assessment in October of 2011. ·	

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	The "Transdisciplinary Therapy Screen," dated 6/29/11, indicated Resident #53 had impaired range of motion. The "Hospice Care Plan," dated 7/10/11, indicated Resident #53's daughter requested patient be comfortable without pain and have his contracted hands washed out and nails trimmed and cleaned. The Transdisciplinary Therapy Screening, dated 7/12/11, indicated a quarterly assessment was completed by the Physical Therapist. The report indicated Resident #53 had impaired range of motion and was at risk for skin breakdown, poor hygiene, or pain. The MDS dated 7/12/11, indicated Resident #53 had no impairment in range of motion of either upper or lower extremities. The instructions for coding the functional limitation in range of motion on the MDS was provided by MDS Nurse #1 on 8/26/11 at 8:38 a.m. The instructions indicated the intent was to determine whether functional limitation in range of motion (ROM) interfered with the resident's activities		Resident #53 care plan has been updated to reflect diagnosis of end stage dementia. · Resident #53 MDS has been modified to reflect impairment with Range of Motion to both hands. · Resident #53 resident care sheet and care plan have been updated to reflect impairment with Range of Motion to both hands. **What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur:** · Therapy will evaluate residents on admission and on a quarterly basis. Findings will be relayed to MDS Coordinator · MDS will be updated by therapy via Therapy-to-MDS communication form to reflect resident's current Range Of Motion function. · Residents qualifying for hospice care will have qualifying diagnosis indicated on MDS. · In-servicing was done September 9, 2011 by MDS Coordinator. · MDS Coordinator/Designee and Nurse Management are responsible for overseeing compliance. · Resident #53 has a clarification order stating diagnosis of end stage dementia and MDS will be updated at next quarterly assessment in October of 2011. · Resident #53 care plan has been updated to reflect diagnosis of end stage dementia. · Resident #53 MDS has been modified to reflect impairment with Range of Motion to both hands. · Resident	

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	of daily living or places him or her at risk of injury. An interview was conducted with LPN #10 on 8/24/11 at 10:35 a.m. During the interview, the LPN indicated Resident #53 had contractures to bilateral hands and arms. She further indicated the resident in the past used carrots (carrot shaped device for hands) and wash cloths in his hands for the contractures but the resident did not like them and would grimace with their use. An interview was conducted with MDS Nurse #1 on 8/24/11 at 11:15 a.m. During the interview, she indicated she obtains information for completing the MDS from therapy, care sheets, etc. She further indicated Resident #53 was dependant for care so this couldn't affect his daily care so she did not mark the MDS with decreased range of motion. During an interview on 8/24/11 at 3:31 p.m. with Resident #53's daughter, she indicated he has contracted hands that have to be physically opened by staff in order to clean them. She also indicated the resident's left hand had been contracted for 3 or 4 years and after a small stroke, the right hand developed		#53 resident care sheet and care plan have been updated to reflect impairment with Range of Motion to both hands. · MDS Coordinator and Rehabilitation Service Manager will in-service all therapy staff and restorative aides on Communication Form, Range of Motion evaluation. In-service will be completed by September 24, 2011. · Residents being admitted to hospice services will have the current diagnosis for qualifying illness brought forward to the MDS. This will be reviewed by the Nurse Managers in the Morning Meeting. In-service on this procedure was done by DNS with Nurse Managers on September 8, 2011. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** · A CQI monitoring tool called MDS Diagnosis which includes Range of Motion and end of life diagnosis will be utilized every week x 4, monthly x 3 and quarterly x 2. · Data will be collected by DNS/Designee from 1 st and 2 nd shifts and submitted to the CQI committee. If threshold is not met, an action plan will be developed. · Non-compliance with facility procedures may result in disciplinary action up to and including termination. **Completion**	

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	contractures. 2. The MDS dated 4/20/11 and 7/12/11, indicated Resident #53 did not have a condition or chronic disease that may result in a life expectancy of less than six months to live. The MDS for both 4/20/11 and 7/12/11 indicated the resident was receiving hospice services. The care plan "Resident is receiving hospice services related to diagnosis of: general decline," dated 4/21/11, indicated Resident #53 was receiving hospice services The "Nursing Facility Resident Hospice Election Notification," dated 4/11/11, indicated Resident #53 had a terminal diagnosis. 3.1-31(d)		**Date: 9/24/2011**	
F0282 SS=D	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, record review, and interview, the facility failed to follow the care plan for back support during meals, for 1 resident of 40 residents reviewed for care plans in the stage 2 sample of 40. (Resident #53)	F0282	**F 282 Services by Qualified Persons/Per Care Plan** It is the practice of this facility to ensure that each resident's individualized care plan is updated to reflect the current physician orders. However, based on the alleged deficient practice the following has been implemented:	09/24/2011

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	Findings include: The clinical record for Resident #53 was reviewed on 8/24/11 at 10:30 a.m. Diagnoses included, but were not limited to, left hip fracture, polio, fractured left shoulder, and Alzheimer's dementia. The "Physician's Orders/Plan of Care," dated 7/10/11, indicated Resident #53 utilized a lumbar support pillow. On 8/22/11 at 12:00 p.m., Resident #53 was observed in the assist dining room in a comfort chair. No back cushion was observed in the chair. On 8/24/11 at 11:26 a.m., Resident #53 was observed in the assist dining room in a comfort chair. No back cushion was observed in the chair. On 8/25/11 at 11:30 a.m., Resident #53 was observed in the assist dining room in a comfort chair. No back cushion was observed in the chair. On 8/26/11 at 12:00 p.m., Resident #53 was observed in the assist dining room in a comfort chair. No back cushion was observed in the chair. The current CNA assignment sheet		**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** · Resident #53's care plan and resident care sheet accurately reflects current physician's orders for positioning. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** · No other residents were found to have been affected by the alleged deficient practice. · Resident care plans will be reviewed with the resident care sheets on ongoing basis with Care Plan Team after Morning Meeting to assure continuity of resident care per physician orders. · Care Plan Team was educated on process by ADNS on September 9, 2011. · ADNS/Designee is responsible to oversee compliance. · All care plans will be reviewed by September 24, 2011 to ensure physician orders on adaptive equipment are followed.	

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	was provided by MDS Nurse #1. The assignment sheet indicated a pillow was to be placed behind the back of Resident #53 for positioning when eating. On 8/24/11 at 11:26 a.m., Hospice Aide #12 was queried on Resident #53's cushions. The aide pointed to the seat cushion as being the only cushion used in the chair. 3.1-35(g)(2)		**What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur** · ADNS/Designee will review residents care sheets daily until all current residents are completed. · Resident care sheets will be updated by ADNS/Designee during morning meeting as physician orders are read and reviewed by IDT. · The Staff Development Coordinator/Designee will in-service Interdisciplinary Team by September 24, 2011. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** · A CQI monitoring tool called Resident Care Sheet will be utilized every week x 4, monthly x 3 and quarterly x 2. · Data will be collected by DNS/Designee from 1 st and 2 nd shifts submitted to the CQI committee. If threshold is not met, an action plan will be developed. • Non-compliance with facility procedures may result in disciplinary action up to and including termination.	

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F0325 SS=D	Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. Based on observation, record review and interview, the facility failed to prevent weight loss in 1 of 8 residents with weight loss of 22 who met the criteria for nutrition. (Resident #82) Findings include: The clinical record for Resident #82 was reviewed on 8/22/11 at 2:00 p.m. Diagnoses included, but were not limited to, anemia, dementia, diabetes, depression, and aphasia (difficulty speaking). The care plan for at risk for adverse effects of high or low blood sugar, dated 4/19/11, indicated "...diet as ordered, monitor intakes and offer replacements for less than 75% consumed...." The care plan for requiring mechanically altered diet related to chewing and swallowing difficulties,	F0325	**Completion date: 9/24/2011** **F 325 Maintain Nutrition Status Unless Unavoidable** It is the practice of this facility to promote appropriate nutritional status to avoid weight loss in residents dependent upon staff for feeding. However, based on the alleged deficient practice the following has been implemented: **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** · Resident #82 is on Nutrition At Risk watch list for weekly weight. · Resident #82's Care Plan is current with nutritional risk status. · All Staff involved in resident meal service including but not limited to nursing and dietary staff, will be in-serviced on timeliness of feeding once meal service begins. In-service will be conducted by Staff Development Coordinator/Designee by September 24, 2011. **How will**	09/24/2011

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	dated 7/11/11, indicated the following: "...monitor weight...offer substitute is <75% of any meal is consumed...." There was no current care plan for weight loss. The "Dietary Progress Notes," dated 4/27/11, indicated Resident #82 was receiving a pureed diet with nectar thick liquids, and the resident was fed by staff. The care plan for mechanically altered diet, dated 7/11/11, indicated the resident had a history of chewing and swallowing difficulties and was fed by staff at all meals. The "Weight Variance Report," dated 1/1/11 - 8/23/11, listed the following weights for Resident #82: 8/1/11 - 130 pounds 7/1/11 - 133 pounds 6/1/11 - 135 pounds 5/1/11 - 138 pounds 4/1/11 - 140 pounds 3/1/11 - 142 pounds 2/1/11 - 140 pounds 1/1/11 - 142 pounds On 8/25/11 at 11:30 a.m., Resident #82 was observed in the assist dining room for lunch. The food cart arrived in the dining room at 11:53 a.m., and the following was observed:		**you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** · No other residents were found to have been affected by the alleged deficient practice. · All residents with gradual weight loss and dependent upon staff for nutritional intake could potentially be at risk. · Meal consumption records will be monitored by Nurse Managers on daily basis. · Weights will be monitored by NAR committee on weekly basis. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur:** · Resident's consuming less than 75% of meal will be offered replacement · All resident's having gradual weight decline will have care plan addressing current interventions. · All resident's requiring staff assistance with meal consumption will be fed timely. · Resident meal intake will be documented correctly to reflect the accurate amount consumed. · Staff Development Coordinator/Designee will provide in-service training to all staff assisting with meal service and Nutrition At Risk (NAR) members by September 24, 2011. In-service will include but not limited to accurate documentation	

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	155756	A. BUILDING 00 B. WING	08/26/2011

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	11:54 a.m., Resident #82's food was placed in front of him and uncovered. His lunch included 3 nosey cups of beverages. 11:57 a.m., a tablemate took a bite of Resident #82's mashed potatoes and staff ordered new potatoes from the kitchen. 11:57 a.m., Resident #82 reaching and grabbing at his food. 12:01 p.m., Qualified Medication Aide (QMA) #8 entered the dining room to assist Resident #82 and the rest of his tablemates with lunch. 12:02 p.m., QMA #8 sat down to assist with lunch. 12:03 p.m., Resident #82 grabbed at his plate and knocked off a glass of his juice which was never replaced. QMA #8 then started to clean up the spilled juice. 12:04 p.m., Resident #82 still waiting for first bite and reaching for food. 12:07 p.m., Resident #82 received his first bite of food thirteen minutes after it was first delivered and uncovered. 12:09 p.m., received a bite of food 12:10 p.m., received a bite and a drink 12:12 p.m., received a bite of food 12:13 p.m., received a bite of food 12:14 p.m. received a bite of food 12:15 p.m. received a bite of food 12:16 p.m., received a bite of food 12:25 p.m., received a sip of his drink		and knowing how to encourage residents to eat at all three meals. · Staff Development Coordinator/Designee will provide in-service training to all dining room managers by September 24, 2011. In-service will include but not limited to accurate documentation and knowing how to encourage residents to eat, monitoring consumption, including all dining rooms and all three meals. · NAR committee is responsible for overseeing compliance. · Staff will be monitored by dining room managers to ensure staff is providing necessary assistance to residents. · Meal consumption records will be monitored by nurse managers on daily basis and includes a paper review in conjunction with direct observation by the dining room manager/Designee comparing documentation with actual observations to ensure the documentation is accurate. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** · A CQI monitoring tool called Meal Consumption will be utilized every week x 4, monthly x 3 and quarterly x 2. The CQI tool includes a paper review in conjunction with direct observation by the dining room manager/Designee comparing documentation with actual	

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	12:26 p.m., received a bite of food 12:27 p.m., received a bite of food and a sip of his drink 12:28 p.m., received a bite of food 12:29 p.m., received a bite of food 12:29 p.m., received a bite of food 12:30 p.m., received a bite of his drink 12:31 p.m., the resident was reaching out towards his food, he then received his 15th bite of food and his 5th sip of his drink 12:35 p.m., resident consumed less than 50% of lunch. 12:37 a.m., all staff in dining room done feeding residents and starting to take all residents back to their rooms. The "Food/Fluid Intake Record,", dated August 2011, listed Resident #82 as having consumed 100% of lunch on 8/25/11. An interview was conducted with QMA #8 on 8/26/11 at 10:27 a.m. During the interview, she indicated Resident #82 ate about 50% percent of his lunch on 8/25/11 and drank his liquids. She further indicated he was sleepy and she had to keep waking him up. She also indicated nursing is responsible for documenting meal consumption. 3.1-46(a)(1)		observations to ensure the documentation is accurate.· Data will be collected by DNS/Designee from 1 st and 2 nd shifts and submitted to the CQI committee. If threshold is not met, an action plan will be developed. · Non-compliance with facility procedures may result in disciplinary action up to and including termination. **Completion date: 9/24/2011**	

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F0356 SS=C	The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. Based on observation and interview, the facility failed to post the licensed and unlicensed nurse staffing hours on 1 of 5 days observed. This had the potential to affect 141 of 141 residents at the facility and their visitors.	F0356	**F 356 Posted Nurse Staffing** It is the practice of this facility to post daily the licensed and unlicensed nurse staffing hours. The following has been implemented:	09/24/2011

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	Findings include: 1. During the initial tour of the facility, beginning at 9:25 a.m., on 8/22/11, the nurse staffing hours were observed posted in a glass case on the wall, on 500 hall. The total number of hours for licensed and unlicensed staff were posted, however, the staffing form was dated 8/8/11. The Director of Nursing Services (DNS), was interviewed, at 8:20 a.m., on 8/26/11, and indicated QMA # 8 was responsible for posting the staffing hours, but had been on vacation, and no one was assigned to post the staffing hours while she was on vacation. The DNS was interviewed, at 12:30 p.m., on 8/26/11, and indicated the facility did not have a policy for posting the staffing hours. 3.1-13(a)		**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** · The daily staffing pattern will be posted on a daily basis per guidelines. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** · The Nurses Scheduler/Designee will post staffing pattern daily and Nurse Supervisors will update at beginning of shift. · All residents have the potential to be effected by the alleged deficient practice. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur** · Re-training of Nurse Scheduler and Nurse Supervisors was done on September 9, 2011 by Director of Nursing Services. · The Director of Social Services will check to ensure it is updated due to the office location is directly across the hall from the posting site.	

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			· Director of Nursing Services is responsible to oversee compliance. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** · A CQI monitoring tool called Nurse Schedule will be utilized every week x 4, monthly x 3 and quarterly x 2. · Data will be collected by DNS/Designee from 1 st and 2 nd shifts and submitted to the CQI committee. If threshold is not met, an action plan will be developed. • Non-compliance with facility procedures may result in disciplinary action up to and including termination. **Completion date: 9/24/2011**	
F0371 SS=E	The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, record review and interview, the facility failed to wash hands for the recommended amount of time and after touching a soiled surface during dining, handle	F0371	**F 371 Food Procure, Store/Prepare/Serve-Sanitary** It is the practice of this facility to store, prepare, distribute and serve food under sanitary conditions. However based on the	09/24/2011

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	glasses of beverages served to residents without touching the drinking rims of the glasses, and feed finger foods to residents without the use of bare hands potentially affecting 91 residents who ate their meals in 3 of 5 dining rooms of 141 residents residing in the facility. Findings include: 1 On 8/22/11 at 12:10 p.m., CNA #13 was observed to pick up a fork off of the floor before performing a six second hand wash, directly under the water, in the assist dining room before continuing to pass trays to residents. QMA #8 was observed on 8/22/11 at 11:34 a.m. performing a 6 second hand wash after repositioning a resident. On 8/22/11 at 12:03 p.m., QMA #8 was observed cleaning up spilled juice from the floor of the assist dining room and then wash her hands for 4 seconds before assisting Resident #27 with putting her clothing protector on. After that, the QMA used hand sanitizer and sat down to feed residents. On 8/22/11 at 12:23 p.m., QMA #8 was observed to pull a resident up in		alleged deficient practice the following has been implemented: **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** · Dietary Manager/Designee will in-service all staff assisting with meal service. Education and training will include but not limited to proper hand washing procedure, proper handling of glasses when delivering liquids, and proper way to assist residents with finger foods. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** · All residents receiving fluids and finger foods at meal time has potential to be affected by practice. · Dietary Manager/Designee will in-service all staff assisting with meal service. Education and training will include but not limited to proper hand washing procedure, proper handling of glasses when delivering liquids, and proper way to assist residents with finger foods.	

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	her chair and then perform a 10 second hand wash. 2. QMA #8 was observed pick up a french fry with her bare hands and feed to Resident #27 on 8/22/11 at 12:08 p.m., 12:09 p.m., 12:11 p.m. On 8/22/11 at 12:13 p.m. and 12:16 p.m., LPN #10 was observed to pick up a french fry with her bare hands and feed to Resident #27.		· In-service training on hand washing with return demonstration, and proper handling of tableware will be completed by September 24, 2011 by Dietary Manager. · Dining Room Managers are responsible to oversee compliance in all dining rooms and all three meals including the Memory Care Facilitator overseeing compliance in the Memory Care dining room. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur:** · Dietary Manager/Designee will in-service all staff assisting with meal service. Education and training will include but not limited to proper hand washing procedure, proper handling of glasses when delivering liquids, and proper way to assist residents with finger foods. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** · A CQI monitoring tool called Sanitary Conditions will be utilized every week x 4, monthly x 3 and quarterly x 2.	

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	3. During an observation of the lunch meal in the Memory Care Unit on 8/22/11 at 11:55 a.m., all residents were in the dining room and seated at tables ready for lunch. Memory Care Unit staff were observed passing beverages prior to the delivery of the steam table. Certified Nursing Assistant (CNA) #3 was observed to do the following: at 11:59 a.m. she was observed serving two glasses of juice to two residents at a dining table by placing the glasses side by side and carrying the glasses to the dining table by placing her thumb and fingers inside the glasses, pressing her fingers to the inside of the glasses, and touching the drinking rims of the glasses; at 12:00 p.m., CNA #3 was observed to serve two glasses of water to two residents at a dining table in the same manner; at 12:03 p.m., she was observed to serve two glasses of water and three glasses of milk to three residents at a		· Data will be collected by DNS/Designee from 1 st and 2 nd shifts and submitted to the CQI committee. If threshold is not met, an action plan will be developed. · Non-compliance with facility procedures may result in disciplinary action up to and including termination. **Completion date: 9/24/2011**	

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	dining table in the same manner; at 12:04 p.m., she was observed to serve two glasses of juice, two glasses of milk, and a glass of water in the same manner., and at 12:05 p.m., she was observed to serve two glasses of water to two residents at a dining table in the same manner. The residents were observed to drink from the glasses. 3. During an observation of the lunch meal in the Memory Care Unit on 8/25/11 at 11:55 a.m., CNA #4 was observed to carry three glasses of chocolate milk to three residents seated at a dining table. She carried one glass in one hand and two glasses in the other hand by placing the two glasses side-by-side and placing her open palm over the drinking rims of the glasses to hold them together with her palm touching the rims. At 12:00 p.m., CNA #4 was observed to carry three glasses of lemonade to three residents seated at a dining table. She carried one glasses in one hand and carried two glasses in the other hand by placing the two glasses side-by-side and placing her open palm over the drinking rims of the glasses to hold them together with her palm touching the rims. The residents were			

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	observed to drink from the glasses. During an observation of the main dining room at 12:25 p.m., LPN #5 was observed to cut up Resident #13's cookie and feed her bites of cookie with her bare fingers which Resident #13 accepted and ate. The Dietary Manager was interviewed at 8/26/11 at 9:10 a.m. During the interview she indicated drinking glasses should not be handled by touching the rims. She also indicated staff should not touch food fed to residents with their bare hands. A current facility policy "General Food Preparation and Handling", revised on 4/11, indicated "...Handle utensils, cups, glasses, and dishes in such a way as to avoid touching surfaces with which food or drink will come into contact...Bare hands should never touch raw or ready to eat food directly...." 3.1-21(i)(3)			

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F0425 SS=D	The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.			
	Based on observation, record review, and interview, the facility failed to ensure correct labeling of medications for 2 of 10 residents observed during the medication pass, Residents #86 and #46. Findings include: 1. During observation of the medication pass, with LPN #6, at 8:28 a.m., on 8/25/11, the LPN gave resident #86 Cymbalta 30 milligrams (mg) 2 capsules, by mouth. The directions on the label indicated the resident was to receive 30 mg. of Cymbalta, by mouth, daily. The LPN indicated the Cymbalta had been increased to 60 milligrams on	F0425	**F 425 Pharmaceutical Svc – Accurate Procedures, RPH** It is the practice of this facility to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biological) to meet the needs of each resident. However, based on the alleged deficient practice the following was implemented: **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** · Resident's #86 and 46 have clearly marked labels on	09/24/2011

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	8/19/11, however a label change had not been placed on the medication label. The LPN was then noted to place a sticker which indicated a direction change for the medication. LPN #6 was observed to give resident #46 3 units of Humalog insulin,100u/ml (milliliter), subcutaneously, at 8:37 a.m., on 8/25/11. The directions on the insulin box, which contained the bottle of insulin, indicated to give 6 units of Humalog insulin. LPN #6 indicated the resident used to receive 6 units of Humalog insulin, but the order had been changed, and the resident now received 3 units of Humalog. At this time, the LPN was noted to place a direction change sticker on the insulin box. Review of the medication administration record for resident #46 indicated the Humalog insulin was changed to 3 units on 7/29/11. The DNS was interviewed, at 10:20 a.m., on 8/26/11, and indicated if a medication dosage was changed, the nurse taking the order should either request a new label from the pharmacy, or place a sticker on the bottle to show the change and refer to		medications with dose changes to see MAR for directions. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** · No other residents were found to have been affected by the alleged deficient practice. · Residents having medication dose changes have the potential to be affected by the alleged deficient practice. · Licensed staff will be in-serviced on putting direction change label on the medication. Education will be provided by Staff Development Coordinator/Designee and completed by September 24, 2011. · All Medications were audited by nurse managers to ensure they matched the physician order **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur:** · Licensed staff will be in-serviced on putting direction change label on the medication. Education will be provided by Staff Development Coordinator/Designee and completed by September 24, 2011.	

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	the Medication Administration Record for change. 3.1-25(e)		· Nurse mangers will monitor daily for medication changes and correct labels. · DNS is responsible to oversee compliance. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** · A CQI monitoring tool called Medication Changes will be utilized every week x 4, monthly x 3 and every other month x 3. · Data will be collected by DNS/Designee from 1 st and 2 nd shifts and submitted to the CQI Committee. If threshold is not met, an action plan will be developed. · Non-compliance with facility procedure may result in disciplinary action up to and including termination. **Compliance date: 9/24/2011**	
F0463 SS=D	The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. Based on observation, record review, and interview, the facility failed to ensure a call light in a resident's room was functional, for 1 of 40 residents in the stage 1 sample. (Resident #126) Findings include:	F0463	**F 463 Resident Call System – Rooms/Toilet/Bath** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** · Resident # 126 call light	09/24/2011

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	155756	A. BUILDING 00 B. WING	08/26/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENTRY MEADOWS	7843 W JEFFERSON BLVD FORT WAYNE, IN46804

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	1. During interview, with Resident #126, on 8/22/11, at 2:32 p.m., the bedside call light was tested for proper functioning. The call light was activated, but did not light up over the resident's door, and the resident indicated the call light was not working "last week" and she had reported this to CNA #9. CNA #9 was interviewed, at 2:33 p.m., on 8/22/11, and attempted to test the call light, but it did not work. The CNA indicated he had reported this last week, and had filled out a work order for the non-functioning call light. The Maintenance Supervisor was observed to test the call light, at 2:35 p.m., on 8/22/11, and indicated it was not working. He indicated he had gotten a work order last week. The maintenance man repaired the call light and indicated the "tab" was broke off of the "duty station" so the call light cord would not fit tightly. Review of a maintenance request, dated 8/19/11, provided by the Maintenance Supervisor on 8/25/11, at 11:50 a.m., indicated the call button in resident #126's room was not working. The date completed indicated 8/20/11. 3.1-19(u)(1)		was fixed by Maintenance Supervisor on 8/22/11. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** · All residents have the potential to be affected by the alleged deficient practice. · All maintenance staff will be educated on the procedure of checking the call light system when any malfunction is reported and after the repair has been completed to ensure call light system works properly. The education will be conducted by the Executive Director/Designee and completed by September 24, 2011. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur:** · All Maintenance staff will be re-educated on the procedure of checking the call light system when any malfunction is reported and after the repair has been completed to ensure call light system works properly. Education will be provided by Executive Director/Designee and completed by September 24, 2011. · All staff is being in-serviced by the Staff Development	

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			Coordinator/Designee on the maintenance request system and how to report maintenance problems. In-servicing will be completed by September 24, 2011. · Executive Director is responsible to oversee compliance. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** · A CQI monitoring tool called Call Light System will be utilized every week x 4, monthly x 3 and quarterly x 2. · Data will be collected by DNS/Designee from 1 st and 2 nd shifts and submitted to the CQI Committee. If threshold is not met, an action plan will be developed. · Non-compliance with facility procedure may result in disciplinary action up to and including termination. **Compliance date: 9/24/2011**	
F0464 SS=E	The facility must provide one or more rooms designated for resident dining and activities. These rooms must be well lighted; be well ventilated, with nonsmoking areas identified; be adequately furnished; and have sufficient space to accommodate all activities.			

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	Based on observation and interview, the facility failed to ensure adequate space for dining in 1 of 5 dining rooms observed for 26 of 42 residents who ate their meals in the main dining room. Finding includes: On 8/22/11 at 12:00 p.m., during observation of the main dining room, residents were seated at tables and coming into the dining room. Staff were assisting in moving residents so other residents could get to their tables at the end of the dining room farthest from the kitchen. Observation of the far end of the dining room indicated 7 tables with a total of 26 residents seated at the tables. Residents already seated at their table were observed to be moved from the table so other residents could get through, and then taken back to their table. Observation on 8/25/11 at 12:00 p.m. indicated residents seated at tables at the far end of the dining room and being moved from the table so other residents could get to their table. Four residents were observed to be moved and then moved back to their table.	F0464	**F 464 Requirements for Dining & Activity Rooms** It is the practice of this facility to provide a dining room that has sufficient space to accommodate all activities. However based on the alleged deficient practice the following has been implemented: **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** · The dining room tables were moved on September 8, 2011 to the exterior walls for 26 of the 42 residents in the main dining room to assure adequate space. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** · All residents who eat in the dining rooms have the potential to be affected by the alleged deficient practice. · All Nurses and Dining Room managers will be educated on observing to ensure there is adequate space in the dining rooms and reporting any concerns to the Executive Director. The education will be conducted by the Staff Development Coordinator/Designee and	09/24/2011

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	Interview with Resident #57 on 8/25/11 at 12:30 p.m. indicated he always has trouble getting into the dining room in his electric wheelchair. He indicated other residents have to move so he can get to his table. The resident indicated it was like this everyday. On 8/26/11 at 8:50 a.m. interview with the Administrator indicated he had never had complaints from residents related to crowding in the main dining room. The Administrator indicated he would talk with the Dietary Manager and maybe they could re-arrange the tables. Interview on 8/26/11 at 9:00 a.m. with the Dietary Manager indicated last week she had moved the tables on the end of the dining room at an angle and had moved some tables down but indicated staff keep moving them back. 3.1-19(w)		completed by September 24, 2011. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur:** · All Nurses and Dining Room manager will be educated on observing to ensure there is adequate space in the dining rooms and reporting any concerns to the Executive Director. The education will be conducted by the Staff Development Coordinator/Designee and completed by September 24, 2011. · Dining room managers are responsible for monitoring all dining rooms at all three meals for adequate space for all residents. · Executive Director is responsible to oversee compliance. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** · A CQI monitoring tool called Adequate Space will be utilized every week x 4, monthly x 3 and quarterly x 2. · Data will be collected by DNS/Designee from 1 st and 2 nd shifts and submitted to the CQI	

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			Committee. If threshold is not met, an action plan will be developed. · Non-compliance with facility procedure may result in disciplinary action up to and including termination.	
F0514 SS=A	The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on observation, record review, and interview, the facility failed to ensure documentation regarding a new physician order for a medication change was readily accessible, for 1 resident (#86), and for 1 resident related to meal consumption (Resident #82) of 40 residents reviewed for clinical records in the sample of 40. Findings include: 1. During observation of the medication pass, with LPN#6, at 8:22 a.m., on 8/25/11, the LPN was noted to give Resident #86 Cymbalta 30 milligrams, 2 capsules (60	F0514	**F 514 Clinical Records** · It is the practice of this facility to ensure there is accurate documentation regarding a new physician order for a medication change and that meal consumption is documented accurately for every resident. However, based on the alleged deficient practice the following has been implemented: **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** · Resident #86 has clearly marked labels on medications	09/24/2011

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	milligrams). The label on the Cymbalta indicated to give Cymbalta 30 milligrams, by mouth, daily. The LPN indicated the medication had been increased to 60 milligrams on 8/19/11, because of a pharmacy recommendation. The resident record was reviewed, at 9:30 a.m., on 8/25/11, and physician orders for August, 2011, indicated Cymbalta 30 milligrams 1 capsule, by mouth, daily. The Director of Nursing Services (DNS), was interviewed, at 9:48 a.m., on 8/25/11, and indicated she was unable to find the order to increase the Cymbalta to 60 milligrams daily. The Assistant DNS was interviewed, at 10:12 a.m., on 8/25/11, and indicated she had found the pharmacy recommendation, dated 8/18/11, for increasing the Cymbalta for Resident #86 from 30 milligrams to 60 milligrams. The Assistant DNS indicated she found this recommendation in medical record office, but said it should have been placed on the resident's chart, as a physician order. She indicated the pharmacy used the pharmacy recommendation sheet as the physician's order, and indicated she didn't know why it was in medical		with dose changes to see MAR for directions. · Resident #82 meal consumption record will be monitored daily. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** · No other residents were found to have been affected by the alleged deficient practice. · All residents with medication order changes have the potential to be affected by the deficient practice. · All residents have the potential to be affected by inaccurate meal consumption documentation. · Licensed staff will be re-educated on the proper labeling of medication changes to alert staff that dose changes have been made. Education will be provided by Staff Development Coordinator/Designee and completed by September 24, 2011. · All nursing staff will be re-educated on the proper documentation of meal consumption intake policy by Staff Development Coordinator and Dietary Manager by September 24, 2011. **What measures will be put into place or what systemic**	

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	record office, as it should have been placed on the resident's record.		**changes you will make to ensure that the deficient practice does not recur:** · Licensed staff will be re-educated on the proper labeling of medication changes to alert staff that dose changes have been made. Education will be provided by Staff Development Coordinator/Designee by September 24, 2011. · All nursing staff will be re-educated on the proper documentation of meal consumption intake policy by Staff Development Coordinator and Dietary Manager by September 24, 2011. · Nurse Managers are responsible to oversee compliance. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** · A CQI monitoring tool called Meal Consumption will be utilized every week x 4, monthly x 3 and quarterly x 2. · A CQI monitoring tool called Medication Changes will be utilized every week x 4, monthly x 3 and quarterly x 2. · Data will be collected by DNS/Designee from 1 st and 2 nd shifts and submitted to the CQI Committee. If threshold is not met, an action plan will be	

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	2. The clinical record for Resident #82 was reviewed on 8/22/11 at 2:00 p.m. Diagnoses included, but were not limited to, anemia, dementia, diabetes, depression, and aphasia (difficulty speaking). The care plan for at risk for adverse effects of high or low blood sugar, dated 4/19/11, indicated "...diet as ordered, monitor intakes and offer replacements for less than 75% consumed...." The "Dietary Progress Notes," dated 4/27/11, indicated Resident #82 was receiving a pureed diet with nectar thick liquids and that the resident is fed by staff. The care plan for mechanically altered diet, dated 7/11/11, indicated the resident had a history of chewing and swallowing difficulties and is fed by staff at all meals. On 8/25/11 at 11:30 a.m., Resident #82 was observed in the assist dining		developed. · Non-compliance with facility procedure may result in disciplinary action up to and including termination. **Compliance date: 9/24/2011**	

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	room for lunch. At 12:35 p.m., the resident had consumed less than 50% of lunch. At 12:37 a.m., all staff in dining room were done feeding residents and starting to take all residents back to their rooms. The "Food/Fluid Intake Record," dated August 2011, listed Resident #82 as having consumed 100% of lunch on 8/25/11. An interview was conducted with QMA #8 on 8/26/11 at 10:27 a.m. During the interview, she indicated Resident #82 ate about 50% percent of his lunch on 8/25/11 and drank his liquids. She further indicated he was sleepy and she had to keep waking him up. She also indicated nursing is responsible for documenting meal consumption. 3.1-50(a)(2)			